TRANSITIONAL HOME AND COMMUNITY SUPPORT TRAINING (TH&CS)

This service provides training and practice with activities related to daily living and maintenance of a household. The assumption is that the natural environment of a survivor's home and community can afford effective opportunities for learning and practicing skills. Survivors may acquire and retain functional living skills best when these skills are taught in an environment that most closely resembles, or is the environment in which they will use these skills. Actual home and community-based activities shall be used in training.

Emphasis is on teaching strategies directly to the client and family so that they can successfully manage roles and responsibilities for daily living and household operations independently.

The family's ability to assist in this learning process and/or to reinforce the learned skills in the natural environment is considered an integral component of this service.

Services are provided by a Qualified Head Injury Professional (QHIP) directly, or under the supervision of a QHIP. The planning team will determine the composition of the service and assure that it does not duplicate, nor is duplicated by, any other service provided to the individual.

Activities included in this service are:

- Evaluating the family/home environment;
- Identifying strategies that enable the client to effectively compensate for cognitive and/or physical impairments that are barriers to the performance of the types of activities required for independent living and household management. Examples of strategies are: memory notebooks, systematic calendar notes, alarm watches, timers, tape recorders, adaptive writing instrument, etc;
- Providing instruction/training in acquisition of strategies and skills the client requires to independently care for his/her personal needs, to plan, organize and carry out activities appropriate for lifestyle and family role. Examples of training activities are: directing personal care, performing household management chores, menu planning, grocery shopping, meal preparation, budgeting, auto/lawn care, creating and maintaining a weekly schedule, developing emergency contingency plans, arranging and accessing public transportation, scheduling and keeping appointments with social service agencies, attorneys, physicians, etc;
- Training the key family member/person how to support the client in acquisition of habitual use of strategies and self-sufficiency skills; and
- Assisting the family to make adjustments to changes in roles by direct training in techniques, suggesting alternative solutions to common problems, identifying natural supports, or referring family members to appropriate services.

PROVIDER REQUIREMENTS:

The Provider must have a Department of Health and Senior Services (DHSS) Participation Agreement for Professional and Special Services Provider form and Provider Application for the provision of TH&CS. Agencies certified by the Department of Social Services or Department of Mental Health for Personal Care Assistance, Day Habilitation, or licensed in Missouri, as Home

Health Care Providers will be accepted by DHSS as long as direct care staff fulfills the requirements for direct care staff as listed below.

Provider staff serving in the supervisory role:

- Must be a Qualified Head Injury Professional (QHIP) with a bachelor's or master's degree in Rehabilitation Services, Education, Special Education, Social Work, Psychology, Rehabilitation Counseling, or Counseling.
- May supervise up to 12 direct-care staff;
- Must be responsible for development of treatment goals. Activities may be carried out by a direct care staff worker that meets qualifications listed below; and
- Must ensure that the direct care staff worker is trained in intervention methods for specific participants in daily activities identified by the planning team.

Provider staff performing direct care:

- Must have a high school diploma or equivalent;
- Must have completed training in the Primary Skills from the Direct Care Worker Competency List within six months of employment. The Primary skills would include the following six domains:
    1. General Overview;
    2. Working with the Consumer in His/Her Environment;
    3. Professional Role and Job Skills of the Direct Care Worker;
    4. Learning About Community Resources;
    5. Safety and Welfare of the Consumer; and
    6. Policies of the Direct Care Worker's Organizational System.
- Must complete a minimum of five hours per year of continuing education specifically related to job duties, after the first year of employment.

UNIT OF SERVICE	REIMBURSEMENT RATE
1/4 HOUR	$8.50

DOCUMENTATION REQUIREMENTS:

Providers must retain for three years, from the date of service, personnel qualification and training records for services provided, documentation of supervision provided according to the unique needs of the individual, and must furnish or make the records available to inspection or audit by DHSS or its representative upon request.

Providers must retain for three years, from the date of service, fiscal and treatment records that coincide with and fully document services billed to DHSS, and must furnish or make the records available for inspection or audit by DHSS or its representative upon request. Failure to furnish, reveal, and retain adequate documentation for services billed to DHSS may result in recovery of the payments for those services not adequately documented and may result in sanctions to the Provider's participation in DHSS programs. This policy continues to apply in the event of the Provider's discontinuance as an actively participating DHSS Provider through change of ownership or any other circumstance.

Documentation must include evidence of client and family's agreement with and participation in goal setting, and must document regular clinical supervision consistent with the overall service plan.

SERVICE PRODUCT:

Initial written assessment and treatment plan listing specific behavioral objectives directed towards independent living skills. The initial treatment plan must:

- Incorporate information from current and previous assessment of the client's independent living skills;
- Show how the Provider plans to work with the family/significant others to train the client towards mastery in specific skills essential to safe independent living. Documentation must include evidence of the family's/significant other's agreement with and participation in activities to ensure sustainable natural supports;
- Include a monthly progress report to the Adult Head Injury (AHI) Service Coordinator indicating the client's functional changes in targeted independent living skills during the period, successful methods used, barriers to acquisition of skills, and maximum achievement expected;

NOTE: Refer to Treatment Plan and Progress Report.

- Provide documentation of regular clinical staff supervision directing the development of compensatory strategies consistent with the overall service plan and goals; and
- Include an exit transition plan that represents a discussion with the client, family/significant other, and AHI Service Coordinator before withdrawing paid supports. A copy of the transition plan shall be provided to the client/family. The transition plan shall show how the skills acquired through this service will be sustained. The transitional plan shall identify potential areas of ongoing needs that may require lifelong support for consideration by the planning team.

SERVICE LIMITATIONS:

This service:

- **Is limited to 1500 hours per participant lifetime; and**
- Is not intended to provide personal care services, but rather assist participant in learning strategies to function independently.

REFERRAL INDICATORS:

The typical participant appropriate for this service has:

- Specific needs identified for training in functional tasks necessary for successful independent living in the home and community;
- An assessment that recommends the participant receive training in a home/community-based setting rather than a facility-based setting in order to promote the optimal generalization of skills for independent living; and
- Demonstrated the ability to learn and incorporate strategies to make changes in functioning relative to independent living and community participation.

DESIRED OUTCOMES:

- Client resumes previous life role, or role activities are redistributed to other family members/natural supports
- Client is independent in household management, and/or natural supports are in place;
- Client has acquired identified adaptive equipment and has demonstrated proficiency in its use;
- Compensatory strategies are identified and incorporated that enable the client to effectively manage everyday self care and household management tasks as independently as possible;
- Community transportation access is identified and available to the client as needed to live independently;
- Client is able to plan at least one week ahead for normally scheduled events;
- Client demonstrates ability to adjust plans for unexpected events;
- Client has developed a plan and identified contact persons for assistance during unusual circumstances and/or emergency situations; and
- Ongoing unmet needs are identified and referrals have been made for lifelong supportive services as indicated.